Race-Related Stress Among Asian American Veterans: A Model to Enhance Diagnosis and Treatment

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This article addresses theoretical principles and clinical descriptions of the phenomenon of race-related stress and trauma experienced by Asian American Vietnam veterans. A conceptual model of race-based stress is presented, comprised of five principles, by which to understand mental health difficulties that can arise in regard to race-based stressors. The model describes (a) the relationship between life threat and physical similarity to the "enemy," (b) the relationship between fear and prejudice, (c) dehumanization as it impacts race hate and combat indoctrination, (d) additive life threat related to exploitation of one's physical similarity to the "enemy," and (e) race-based remorse. The article delineates factors affecting treatment seeking and disclosure of race-based stresses, guidelines for interviewing veterans about race-related events and ethnic self-worth, and the harmful effects of race hate. © *1998 John Wiley & Sons, Inc.*

• *stress* • *posttraumatic stress disorder* • *race* • *ethnic minorities* • *veterans*

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Introduction

For clinicians in the field of posttraumatic stress disorder (PTSD), the inclusion of "ethnic and cultural considerations" in the latest Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) (American Psychiatric Association, 1994) highlights the need for clinical considerations of the relationship between race prejudice and psychological stress. Although ethnic considerations related to PTSD should have major implications for U.S. ethnic minorities, we note that race-related trauma experienced by ethnic minorities is not mentioned in the Specific Culture Features of PTSD contained in DSM-IV. What is mentioned, appropriately but not exclusively, is the trauma experienced by political immigrants from countries of considerable social unrest and civil conflict.

This article is devoted to describing another population and another type of experience in which ethnicity or race may play a role in the development of stress and trauma symptoms: negative race-based encounters experienced by Asian American (AA) veterans who served in a war zone in which Asians were the "enemy." Although this article pertains to a particular U.S. ethnic population and to a veteran population, the theoretical underpinnings and mechanisms of its operation might be applicable to other ethnic minority populations and nonveteran populations.

Although much attention has been given to combat trauma and its relationship to PTSD among Vietnam veterans, minimal attention has been given to race-based stress of ethnic minority Vietnam veterans of the same race as the "enemy." This article has two purposes: (a) conceptual and (b) clinical. *First,* we intend to provide a *conceptual model* of the operative processes by which AA veterans may have experienced negative race-based encounters while serving in the U.S. Armed Forces. The model examines the following: (a) the relationship between life threat and physical similarity to the "enemy"; (b) the relationship between fear and prejudice; (c) dehumanization as it concurrently impacts racial hostility and combat conditioning; (d) disparate treatment (or additive life threat) related to exploitation of one's physical similarity to the "enemy"; and (e) race-based remorse as an additive readjustment problem. Case examples are provided; all but one example are AA veterans who have sought mental health treatment at a Veterans Administration or Veterans Center. Several had been diagnosed with PTSD. The non–treatment-seeking, nonsymptomatic veteran is so indicated in the text. All veterans used as case examples range in age from the late 40s to 50s.

Second, we will address methods to enhance diagnosis and therapy for race-based negative encounters experienced by AAs who served in Vietnam. Although Scurfield and Blank (1985) explicated 15 questions for clinicians to consider concerning stressors and conflicts that may be unique to minority war-veterans, Penk and Allen (1991) subsequently noted that the problem remains that "many clinicians have not comprehended the additional complications experienced by many American minority Vietnam veterans whose stress reactions are increased by their experiences of not being majority culture members" (p. 45).

Selected Literature Review

Combat-related PTSD is still a chronic problem for Vietnam veterans even after 25 years. The National Vietnam Veterans Readjustment Study (NVVRS) (Kulka et al., 1990) interviewed more than 3,000 Vietnam veterans and estimated that from 13% to 27% of these veterans have PTSD. This amounts to more than 481,000 veterans and attests to the longevity of symptoms related to combat. Although the incidence rate of PTSD for White Vietnam theater veterans was 13.7%, the incidence rates for Hispanics and African Americans were 27.9% and 20.6%, respectively. Laufer, Gallops, & Frey-Wouter (1984), Parson (1985), and Allen (1986) all predict-

ed that differences in race or ethnic experiences among Vietnam veterans explain why members of minority groups evidence greater degrees of maladjustment associated with war experiences than their White counterparts do. Yet, few guidelines exist to assist clinicians in this field of inquiry.

The NVVRS did not study Asian Pacific Islander veterans, yet clinical and descriptive evidence suggests that race-related stress is a current problem among AA Vietnam veterans and that they may have the greatest vulnerability to the development of PTSD (Hamada, Chemtob, Sautner, & Sato, 1988; Kiang, 1991; Loo, 1994). Race-related stressors such as being associated with or mistaken for the "enemy" have been documented by the aforementioned authors. AA veterans have reported race-related stress associated with (a) being mistaken for Vietnamese; (b) being subjected to assaults (verbal or physical) that were related to the veteran's Asian ethnicity; (c) death and near-death experiences related to the veteran's Asian ethnicity; (d) racial stigmatization as an Asian; (e) dissociation from one's Asian identity; and (f) marginalization because of the veteran's Asian ethnicity (Loo, 1994).

A survey of 44 Asian Pacific Islander Vietnam veterans (Matsuoka, Hamada, Kilauano, & Coalson, 1992) found that a majority of these veterans perceived that their ethnicity affected how Vietnamese treated them, a majority perceived the Vietnamese as "similar" or "very similar" to themselves, a majority (53%) were mistaken for being Vietnamese either by fellow G.I.s or by Vietnamese, and a majority (51%) perceived that their ethnicity affected how other G.I.s and commanding officers treated them. There are 88,118 Asian Pacific Islander Vietnam veterans, based on figures from the 1990 U.S. Census (of which 69,241 are Americans of Chinese, Filipino, Japanese, Korean, and Asian Indian background). Extrapolating from the study by Matsuoka et al., there may be close to 50,000 Asian Pacific Islander veterans who had race-related experiences that were potentially distressing, stressful, or traumatic.

An Operative Processes Conceptualization of Race-based Stress and Trauma

How does the visual stimulus of being Asian become associated with life threat? How did negative race-based stereotypes of Asians develop in the Vietnam theater? What is the relationship between race hate and self-worth for the ethnic minority veteran? What are the implications for diagnosis and treatment?

Race-based stress or trauma experienced by ethnic minority veterans is here considered an additional stressor of war that can be pronounced among ethnic minority personnel who served in a war that had the following features: (a) the war was against persons of the same or similar race as the minority individual; (b) the war was located in a country of the same race as the minority individual and where distinctions between "friend" and "foe" were ambiguous; and (c) the war effort was marked with prevalent attitudes of race prejudice toward the race of the "enemy" that were expressed by American military personnel.

The conditions in which race-based stress is proposed to have existed for AA Vietnam veterans, above and beyond combat-related stress, was this: AA Vietnam veterans served in a conflict in which the "enemy" (Viet Cong) was Asian in a country that was Asian, and where "allies" (South Vietnamese) and "enemy" (Viet Cong) were Asian, making the visual distinction between friend and foe difficult for American troops to decipher. The guerrilla nature of warfare, typical of the latter years of the Vietnam conflict, made the distinction between friend and foe all the more confusing to American soldiers. Finally, AA Vietnam veterans served in a war in which race prejudice against Asians was prevalently expressed by the military (Eisenhart, 1975) and among American troops in Vietnam (Lifton, 1973; Leventman & Camacho, 1980; Shatan, 1978). Race prejudice was so prevalent and pronounced that the phenomenon was given a name—the "gook syndrome" (Lifton, 1972). When racially derogatory terms against Asians were used by the

top brass down, disrespect toward Asians was condoned as part of the military culture.

Veterans who are African American (Egendorf, Kadushin, Laufer, Rothbart, & Sloan, 1981; Kulka et al., 1990), Hispanic (Borrego, 1985; Kulka et al., 1990), or American Indian (Holm, 1992a, 1992b) have also reported race or ethnic-related stress in Vietnam. For example, Holm (1992a) hypothesized that American Indian Vietnam veterans suffer PTSD symptoms in relatively significant numbers given their high combat exposure compounded by the stress of alienation from mainstream America. Holm (1992a, 1992b) also found American Indian veterans reporting experiences of having felt discriminated against and subjected to false racial stereotypes about them by non-Indians. They reported experiences of identifying with the North Vietnamese and Viet Cong as an ethnic minority people killed by whites who went into their country and took land that was not theirs, much as whites had done to American Indians.

Although we recognize the existence of race-related stress and trauma among various ethnic minority veterans, we propose that race-based stress was probably more commonly, directly, and intensely experienced in the widest range of race-related experiences by AA Vietnam veterans. Accordingly, an understanding of race-related stress among war veterans can best begin with AA Vietnam veterans.

The United States engaged in three major conflicts in Asia where Asians were both "ally" and "enemy"—World War II, the Korean War, and the Vietnam encounter—all of which exacerbated both existing race prejudice against Asians and confusion toward Asians derived from difficulties deciphering "friend" from "foe." The popularization of the derogatory term "gook" in the Vietnam encounter derived its linguistic origins from the Korean war (Lifton, 1972), and the use of the derogatory term "Jap" derived from World War II was still in use during the Vietnam encounter. These linguistic examples reflect the transwar transmission of race hate against Asians from one war to the next or a following war.

Loo (1994) linked the PTSD symptoms of hypervigilance, increased arousal, detachment, or estrangement from others to four cognitive–emotional processes inherent in the dilemma that faced AA veterans. The *first* was that AA veterans were exposed to cumulative social input about their identity (Asian) that contradicted their cognitive–emotional schema of themselves (American). The *second* was that AA veterans were forced to acquire a racially prejudiced behavioral repertoire that involved language–cognitive labeling ("gook" in reference to Asians), emotional–motivational elements (to "hate Asians and kill Asians"), and sensory–motor elements (physiologic arousal leading to assault on Asians) that contradicted a previously learned positive repertoire about themselves and others of their race and that demeaned the Asian element of their bicultural identity. The *third* operative process was that the AA veteran's cumulative or life-threatening experiences of being mistaken for the enemy by fellow Americans resulted in states of hypervigilance and physiologic arousal, thereby reducing the veteran's sense of safety. The *fourth* process was that the AA's experiences with racial stigmatization and racial exclusion reduced a sense of belonging, and consequently, the veteran was more prone to feeling estranged and detached from others. We propose five principles by which to understand mental health difficulties that can arise for AA Vietnam veterans in regard to race-based stressors.

Five Principles Regarding Race-Based Stresses

Life Threat and Physical Similarity to the "Enemy"

The first principle by which to understand the relationship between combat and life threat for AA Vietnam veterans is that combat, which requires split-second decision making for survival, leads a

soldier to interpret ambiguous visual stimuli as a threat, whether the stimuli are life-threatening or friendly. The American soldier who is confronted with the appearance of an Asian-looking soldier is forced to immediately decide whether he is confronted by the "enemy" (e.g., Viet Cong) *or* by a South Vietnamese (ARVN), ROK (Republic of Korea) soldier, or AA soldier. Where one must quickly decipher whether a South Vietnamese is friend or foe, particularly in guerrilla warfare wherein civilians may be the "enemy," ambiguity is ever present. The safest decision for the GI, correct or not, is to assume he is confronted by the "enemy" and aim to kill. So prevalent was this phenomenon that American troops had sayings to reflect their cognitive rationalization for "killing when in doubt." "If they're slant eyes, they're VC." "If they weren't VC, they're VC now." "If they run, they're VC." Such rationalizations created a "reality" that put ambiguity to rest. It offered self-justification for shooting first or killing innocent South Vietnamese without necessarily attempting to discriminate more closely between enemy and nonenemy. This arbitrary decision making also helped to minimize or eliminate psychological conflict over possible errors in judgment.

"Killing by race" led those who were racially or physically similar to the "enemy" to fear death from either fellow American soldiers *or* the "enemy." Being mistaken for the enemy was a life-threatening event for AA veterans. As one AA veteran stated, "I was in imminent danger" (Anonymous, May 10, 1995, National Center for PTSD). Another stated: "You got to watch out from all sides, front and behind. You think, what if my own soldiers think of me as Vietnamese? In the field, most of the other [American] guys were with me. But when I had to get out on my own, boy, when I'm done, I'd rush back to base camp. The Special Forces might mistake me for Vietnamese" (Loo, 1998a).

The potency of similar physical appearance is embedded in the phenomenon of racial stigmatization. *Stigma* is "an attribute that is deeply discrediting . . . something that detracts from the character or reputation of a person or group" (Goffman, 1963, p. 46), and *stigmatization* is "a social category about which others hold negative attitudes, stereotypes and beliefs" (Crocker & Major, 1989, p. 609). Stigmatized groups are devalued (Crocker & Major, 1989) and may be labeled as deviant, thereby making them targets of prejudice or discrimination. Goffman (1963) referred to the visual stimulus as the "master trait," the characteristic of the individual that serves as the defining stigmatizing attribute. The visibility of the master trait makes for greater conspicuousness, which perpetuates or emphasizes the stigma (Goffman, 1963). In the case of racial stigmatization, racial features—size, stature, skin color, hair color, and facial features—become the attributes upon which majority persons identify an individual as an object of stigmatization.

The Relationship between Fear and Prejudice

The second principle by which to understand the relationship between combat and life threat for AA Vietnam veterans is that negative racial stereotypes of Asians were socially conditioned by the association of fear-of-the-enemy with fear-of-Asians-in-general, which exacerbated existing race prejudices against Asians, and operated like an automatic process among American troops in Vietnam. In Vietnam, present fear of the "enemy" and past racial prejudice against Asians operated jointly to create conditions that represented potential life threat to AAs. Repeated activation of negative racial stereotypes of Asians by American troops reinforced existing negative stereotypes of Asians, and confrontations with the "enemy" in hostile conditions reinforced reactions of fear associated with persons of Asian ancestry.

Borrowing from an information-processing model, Devine (1989) proposed that racial stereotypes operated as automatic processes that often functioned involuntarily and were spontaneously activated by associations and responses that were learned through repeated activation in one's memory. Repeated activation of the stereotype re-

sulted in a well-learned set of associations that were automatically activated in the presence of a member of the target group (Devine, 1989). A number of Vietnam veterans have continued to have war-related traumatic associations triggered, even decades later, simply from exposure to Southeast Asian–appearing people in urban life in the United States. Frequently, this is manifested as rage directed against Asian-appearing individuals who are symbolically viewed as having "caused" or contributed to the war (Krupnick & Horowitz, 1981; Scurfield, 1993, 1994; Scurfield & Blank, 1985).

Racial stereotypes are "beliefs about the personal attributes of a group of people that one attributes to individuals in that group," (Myers, 1993, p. 376) which "serve to justify less-than-human patterns of relatedness" (Blauner, 1972, p. 41). At various points in U.S. history, people of color were considered commodities. This commodity or "less-than-human pattern of relatedness" was reflected in African Americans involuntarily "imported" to the United States to provide labor for plantations in the South; Chinese "imported" as contract labor to construct railroads on the West Coast; Chinese, Filipinos, and Japanese "imported" to Hawaii as plantation laborers; and Mexicans used for cheap labor in California agriculture. Takaki (1983) cites letters from plantation company management containing itemized orders for "Fertilizer" and "Filipinos" listed alphabetically and receipt of orders for "pipe coverings, insulators, bolts, bone meal, and Chinese labor" (p. 24).

Dehumanization: Racial Hostility and Combat Conditioning

The third principle by which to understand the relationship between combat and life threat for AA Vietnam veterans is that dehumanization is common to both combat indoctrination and race hate; thus, the AA veteran, by virtue of his physical association to the "enemy," is subjected to the same hostility and estrangement as the "enemy" or South Vietnamese. Combat training instills "dehumanization of the enemy" as a common method of indoctrination that has an associated outcome—the instilling of attitudes, words, and behaviors that are demeaning or derogatory about the "enemy" that may have racial or ethnic connotations (Eisenhart, 1975; Scurfield, 1992). When combat indoctrination has racial connotations, those Americans of the same race as the "enemy" are placed in greater jeopardy, because they are vulnerable to being acted upon by virtue of race (Asian) rather than nativity (American).

Because the AA veteran physically resembles the very stimulus (the "enemy") that combat conditioning has paired with racial hatred and hostility, the veteran is subjected to the same negative reaction to which the enemy is associated. Unlike the first principle, wherein the veteran is prone to life threat because of being *mistaken* for the enemy, this third principle proposes that the veteran may have been subjected to hostility or feelings of estrangement from others due to secondary conditioning. That detachment or estrangement from others is one symptom of PTSD raises the issue of the possible relationship between race discrimination or racial stigmatization and PTSD.

Blauner (1972) described the "wedge of racism" as "separating men from others of their own species," and "blocking possibilities of common identification and mutual cooperation" (p. 20). Yetman (1985) described how the objective of racism—to maintain unequal status of the minority group and preserve the racial purity and power of the majority group—is achieved through laws, social attitudes, and behaviors that detach or estrange minority group members from majority group members. The nature of racial stereotypes and race prejudice/discrimination/stigmatization is to detach and estrange the racially stigmatized members from the association of majority group members. Mitchell (1979) defines ethnic alienation as "the estrangement of the individual from key aspects of his or her social existence" (Mitchell, 1979, p. 4).

Exposure to racial hatred elicited experiences of "intense fear" among some AA veterans. As one veteran described it:

> In my first two weeks in Vietnam, I arrived at base camp and the rest of the unit there, all seven guys, turned to stare at me. The look in their eyes was sheer hatred. I arrived with a White guy. He wasn't stared at like I was. That look terrified me. I thought to myself, as soon as the opportunity came, I'd be blasted. *I* knew I was an American, 100%! But that's not how *they* saw me (Loo, 1998b).

One veteran commented: "I had to keep my eyes on the VC *and* the red-necks. You never knew. I was scared all the time. And I still feel fear today" (Anonymous, May 10, 1995, National Center for PTSD).

Where the distinction between Viet Cong and South Vietnamese was blurred because of race similarity, some AA veterans have reported that distinctions were further blurred because AA soldiers wore uniforms that were the same color (olive green) as South Vietnamese soldiers. One non-treatment-seeking Chinese American lieutenant in the U.S. Army reported:

> I had to be very careful because of my ethnicity. When I took a shower, I went right up to the shower in my full uniform. The other guys (Whites) would go to the shower with a towel around their waist. I gave eye contact to *each one* of the GIs going into the shower before I began stripping. Once in a mess hall facility, a sergeant yelled at me: "Hey gook, what the fuck are you doing here?" I turned around. He saw that I was an American and apologized. I felt embarrassed for him. I was very aware that I was always being observed (Anonymous, March 29, 1996, National Center for PTSD).

Race hate against Asians served to neutralize feelings on the part of American soldiers about participation in acts of abuse and atrocities against Vietnamese (Laufer et al., 1984). We propose that an awareness of "abuse by race" was very disturbing to those potentially affected, namely, AAs who served in the Vietnam war zone (and secondarily, by U.S. military personnel who were of other ethnic minority ancestry). Referring to the constant stares given him by White American soldiers, one AA described the meaning he gave to their stares: "It's the attitude, a condescending attitude, that's saying 'You don't belong here'" (Loo, 1998a).

Being called a "gook" had aversive connotations to another veteran: "It meant—you're a worthless piece of shit!" (Loo, 1994). Reflecting further on the impact of cumulative acts of hostility that the veteran interpreted as race-based, the veteran confided: "The Vietnam experience stripped me of my dignity as a human being" (Loo, 1998a).

Additive Life Threat Associated With Being Used as the Enemy

The fourth principle by which to understand the relationship between combat and life threat for AA Vietnam veterans is that disparate treatment of AA soldiers (or additive life threat) related to exploitation of their physical similarity to the "enemy" exposed them to greater potential of and actual life threat. Racial discrimination is "unjustified negative behavior" that is demonstrated toward the individual or group of persons of a minority racial group (Myers, 1993, p. 377) and involves differential treatment of members of a minority group. Race discrimination, the behavioral response that develops out of prejudice, is "the operation of processes of exclusion of people of certain racial categories from the enjoyment of privileges that are enjoyed by members of other categories" or "the art or practice of granting or denying members of particular ethnic categories or groups access to life opportunities or rewards because of their assumed physical, cultural, and/or behavioral characteristics" (Vladislav & Tomovic, 1979, p. 53).

Some AA veterans with PTSD have described what they believed to be disparate treatment—being assigned to "do point" or be tunnel rat—more than American soldiers of non-Asian ethnicity. "Doing point" exposed men to more death, threat of death, and hand-to-hand combat, thereby increasing their potential exposure to threat of

harm or death. Being tunnel rat exposed men to more horrific traumatic events, as illustrated by a Chamorro veteran who described a scene of mangled civilians in the tunnel he was sent to scout (Sal Ueda, personal communication, Guam Vet Center, July 6, 1995).

Attribution for disparate treatment may vary as a function of past experience with race discrimination. Sal Ueda, Team Leader of the Guam Vet Center, describes how past inexperience with race prejudice among Chamorros led many of those who were asked to do more dangerous or undesirable assignments to *initially* attribute this disparate treatment to competence, only *later* to attribute it to race discrimination when expected outcomes for accomplishments were not forthcoming.

> While some Chamorros initially believed that they were treated differently because their superiors considered them more instinctive or competent, when expected rewards such as respect, recognition, or simply a break were not forthcoming, these men reacted with anger at being racially exploited (Sal Ueda, personal communication, July 6, 1995).

Disparate treatment that involved being "used as the enemy" can also create race-related stress. A Filipino American veteran diagnosed with PTSD recalled how his acceptance of being repeatedly assigned the duties of "tunnel rat" abruptly ended when, on the day before his discharge, his sergeant ordered him to be tunnel rat in an area known to be overrun with VC. The veteran recalled reacting with an outburst of anger that he feared led him to retaliate against the sergeant, an event that causes him great distress today. Currently, this veteran presents with symptoms of depression, anger, and guilt for retaliatory actions in which he believes he may have engaged.

A treatment-seeking Chamorro, who reported having been repeatedly singled out to "do point" and never given a break after such duty, came to hate the assignment and fantasized revenge against his African American sergeant. Today, "he experiences intense anger whenever he sees an African American" (Sal Ueda, personal communication, July 6, 1995). Another AA veteran in treatment for PTSD had a postmilitary history of unstable employment whenever he was supervised by a White man. The veteran reexperienced distressing recollections of racial harassment by his White sergeant in his postmilitary life whenever he felt unfairly accused or criticized by someone of the White race in a position of authority.

Race-based Remorse as an Additive Readjustment Problem

The fifth principle by which to understand the relationship between combat and life threat for AA Vietnam veterans is that the AA, fearful of being suspected of disloyalty by fellow American soldiers, may have dehumanized South Vietnamese civilians in ways that led to later feelings of regret or remorse. Guilt or remorse over death, abuse, or atrocities committed while in Vietnam constitutes a readjustment problem that many war veterans with PTSD express. However, we contend that it may be even more pronounced and complex when the dehumanization included a component related to one's own race. Although this principle may not appear life threatening compared with the other principles, it is important to note that many AA believed *then* that being seen as a loyal American by other GIs was critical to their survival.

Several AA veterans (as well as other ethnic minority and some White veterans) have described remorse for not voicing their objections to racially derogatory or racially demeaning actions on the part of White GIs in their company. Asian Americans may describe feeling deterred from voicing their true feelings because "I wanted so badly to be [seen as] an American" (Anonymous, March 29, 1996, National Center for PTSD). Frequently seen by Vietnamese as physically sim-

ilar to them and consequently frequently exposed to friendly gestures on their part (e.g., "Do you have a Chinese name? Could you write it?"), one non-treatment-seeking veteran distinguished how, when *in* the presence of other GIs, he shunned his "hooch maid" (slang term for a South Vietnamese civilian female who was hired to provide cleaning functions in the GI's living quarters) when she made friendly overtures toward him, but when they were *outside* the presence of other GIs, he chatted and exchanged greetings with her. Assigned to a Vietnamese company, this AA became very close to a Vietnamese soldier in that company. "But as soon as I got back to base, I consciously stayed away from him. I didn't want them to think I was siding with the Vietnamese. I was very aware. It was a very conscious thing." The veteran recalls an event when a White soldier in his company, in a mistaken attempt to scare a young Vietnamese boy who was walking with his water buffalo, shot the boy in the chest. "The men took up a collection and paid $250 for the little boy." Today, this AA veteran feels disgust that they would have considered the boy to be worth so little. "I regret I didn't scream and holler then, but I wanted so much to belong to the American enterprise that I didn't want to make a scene." In terms of enduring effects, the veteran stated, "I regret it now. I feel sadness and anger for not having the balls to stand up."

This officer recalled White GIs who avoided using racially derogatory terms against Asians around him, or if they did, expressed an awareness of its possible effects on him. The veteran's White commanding officer asked him twice, "Would it bother you if I used the term 'gook'?" At the time, the AA officer said "no," but today, reflecting on his regret for succumbing to anti-Asian social pressures, he states he would say, "Yeah, it would bother me!"

A treatment-seeking AA veteran recalled "kicking Vietnamese children" in the presence of White GIs in order to dissociate himself from them racially (Anonymous, March 22, 1994, National Center for PTSD). Another treatment-seeking veteran with PTSD described feeling forced to act more negatively to civilian Vietnamese to prove his U.S. loyalty:

> I was a banana then [yellow on the outside, white on the inside]. It was much later, after seeking treatment at the San Francisco Vet Center, that I became comfortable with my Asian identity. I immersed myself in Asian culture and became a "poha" [yellow on the outside and yellow on the inside]. My White self had to commit suicide and the seeds of my Asian roots sprouted and flowered (Anonymous, July 12, 1995, National Center for PTSD).

To summarize, the five principles by which to understand the relationship between combat and life threat for AA veterans included: (a) combat, which requires split-second decision-making for survival, leads a soldier to interpret ambiguous visual stimuli as a threat, whether the stimuli are life threatening or friendly; (b) negative racial stereotypes of Asians were socially conditioned by the association of fear-of-the-enemy with fear-of-Asians-in-general, which exacerbated existing race prejudices against Asians, and operated like an automatic process among American troops in Vietnam; (c) dehumanization is common to both combat indoctrination and race hate; thus, the AA veteran, by virtue of his physical association to the "enemy," is exposed and can be subjected to the same hostility and estrangement as the "enemy" or South Vietnamese; (d) disparate treatment of AA soldiers (or additive life threat) related to exploitation of their physical similarity to the "enemy," exposed AAs to greater potential and actual life threat; and (e) fearful of being suspected of disloyalty by fellow American soldiers, AAs may have dehumanized South Vietnamese civilians in ways that led to later feelings of regret or remorse. Having reviewed five principles by which to understand the relationship between combat and life threat for AA veterans, we now discuss their implications for diagnosis and treatment.

Implications for Diagnosis and Treatment

Diagnosing Race-Relevant Symptoms/Disorders

Given the factors described earlier, we propose that there is a strong likelihood that an AA Vietnam veteran (and perhaps, to a lesser extent, other ethnic minority veterans) will have experienced at least some race-related stress or trauma. The empirical question, not yet answered, is whether Asian American veterans of this and other wars (e.g., World War II or the Korean War) may have had race-related experiences that were negative in impact to such a degree as to contribute to, if not be sufficient to meet, partial or full PTSD criteria. Exposure to such events and associated symptoms must not be ignored or discounted by clinicians who treat this ethnic population.

For ethnic minority veterans in general, and for AA veterans who fought in a war against an Asian country in particular, the commonly developed construct of "war-related PTSD" has not included "race-related stress" as a recognized component. Thus, both the veteran and the therapist generally have not thought to ensure that this topic is specifically discussed, and in sufficient depth, to be able to "rule out" or identify a significant presence or absence of race-related stress exposure. It is possible that negative race-related experiences may at least partly if not substantially explain PTSD diagnosis or symptoms, and it behooves the clinician to explore this possibility.

The lack of systematic and sufficient clinical attention to possible race-related stress exposure and symptoms may be due to various factors: (a) the lack of conceptual awareness of its potential relevance in terms of discrete and/or cumulative exposure, (b) discomfort on the part of the veteran and/or therapist to identify or discuss race-related traumatic experiences, and/or (c) preoccupation by the therapist and/or veteran on the most commonly accepted and identified aspects of war-zone trauma exposure—exposure to death and dying or atrocities. We argue for empirical research to study race-related stress events experienced by ethnic minority veterans to ensure a complete assessment of PTSD and related symptoms.

Factors Affecting Treatment Seeking and Disclosure of Race-Related Trauma

Reluctance on the part of AA veterans to disclose traumatic race-based experiences may be due to fear of encountering anti-Asian prejudice from other veterans in a mixed-race treatment group or from non-Asian treating staff (Loo, 1998a) or to a fear of re-experiencing distressing recollections of past events in which he/she was not treated as an American.

A sole AA veteran in a mixed-race treatment group can be potentially harmed (or benefited) by a situation in which race or ethnic issues are raised. If non-Asian group members or group facilitators are not responsive to the AA's race-related concerns and/or react negatively, or if anti-Asian language is used in the group, the AA veteran's conditioned fear of further exposure to anti-Asian attitudes can be reinforced, thereby increasing the detachment, isolation, alienation, or anger of the AA veteran toward members of the group, the group itself, or the program. In some cases in which such disclosures were handled well, an AA veteran benefited from having disclosed race-related stressors, because a White American group member responded with heartfelt apology to the veteran for others of his race. Such apologies can benefit the AA veteran by reducing feelings of racial alienation and generalized antagonism toward persons of the perpetrator's race. Furthermore, such disclosures can positively reinforce the AA veteran to disclose race-related experiences as part of treatment. Some clinicians have noted that discussions of race-related events can benefit both the discloser (the minority veteran) and the listener (the nonminority veteran) (Alan Perkal, personal communication, May 15, 1996), enlightening both as to the harm of race hate.

Hyperviligance to feared anti-Asian race hate that affects treatment-seeking behavior among AA veterans may be compounded by AA veterans' fear of reexperiencing distressing recollections of having been previously perceived as *non*-American while on military duty. AA veterans may have felt a strong need to be seen as American, which may militate against their willingness to disclose (or even perceive) events in which they were *not* seen as American. Sharing racial experiences of being mistaken for "the enemy" (e.g., Vietnamese) can be humiliating or terror-laden. It can shatter decades (and for some, a lifetime) devoted to being American and identifying as American. An AA veteran's statement "I felt I had to *prove* myself an American" conveys how race-related pressures and prejudices led him to "prove" what should have been *obvious*. Thus, clinicians should be sensitive to factors that discourage disclosure of race-related stress experiences in their efforts to diagnose and treat race-related stress and trauma among AA veterans.

Interviewing about Race-Related Experiences

The clinician is encouraged to use a series of questions or interview prompts to more systematically explore the topic of race-related experiences with the veteran. In addition to generic questions relevant to minority military personnel or relationships with Vietnamese (see Scurfield & Blank, 1985), the clinician is encouraged to explore topics most likely to generate discussion about race-related stress or trauma-based events that may have occurred before, during, or after active military service.

BEHAVIORALLY BASED QUESTIONS. Clinicians can benefit from guidelines on topics of inquiry about behaviorally based, race-related experiences. For each topic presented, we present illustrative items that are variations of items from the Race-Related Experiences Questionnaire for AA veterans (RREQ) being tested by the senior author and her colleagues. The RREQ consists of a pool of more than 100 developmental items that are currently being validated in a funded Veterans Affairs Merit Review at the National Center for PTSD at the Honolulu Veterans Affairs to construct a clinically useful instrument for AA veterans. Clinicians could inquire about the following experiences.

1. Instances in which the veteran may have been called a racially-derogatory name (e.g., "gook") by fellow military personnel, e.g., "Were you ever called a "gook" in a hostile manner?"
2. Instances in which the veteran was stared at by other military personnel when entering an unfamiliar American compound for reasons having to do with the veteran's ethnicity, e.g., "Were you ever stared at when you entered an unfamiliar American compound because of your ethnicity?"
3. Instances in which the veteran was subjected to derogatory or discriminatory treatment for reasons associated with his or her ethnicity or physical similarity to the enemy, e.g., "Did you feel you were ever treated differently from military personnel of another race in ways that were more negative or more dangerous?"
4. Instances in which the veteran was physically assaulted because of physical appearance as an Asian, e.g., "Were you ever physically assaulted because of your ethnicity?"
5. Instances in which the veteran behaved in ways that would be perceived as American, would "prove" themselves American, or would deter from being mistaken for or associated with the Vietnamese or the "enemy," e.g., "How often, if ever, did you take precautions to prevent others from mistaking you for Vietnamese?" or "When approached by Vietnamese, were you ever mean to them in order that other Americans would not identify you as Asian?"

Such inquiry about race-related events should be followed with inquiry about their *impact* on the veteran ("How did that make you feel or behave?") to assess whether there were responses of "intense fear, helplessness, or horror" (DSM-IV Criteria A2) or if there were, alternatively or concurrently, responses of isolation, detachment, or alienation in addition to symptoms indicated in DSM-IV Criteria B, C, or D.

AFFECTIVE-BASED QUESTIONS. Inquiry can also be made about affective-based events that involved race-related fear, hypervigilance, stigmatization, or discomfort. It is our clinical experience that there may be at least four dimensions to consider in this regard. Each of these dimensions is being tentatively considered as possible sub-scales of race-related stress exposure. Illustrative questions are listed for each of the four dimensions: (a) *Fear-based:* "How often, if ever, did you fear being shot or harmed by either side (friendly forces as well as the enemy) because you looked Asian?" "Were you ever concerned that you might be mistaken for Vietnamese, be killed, then end up in a Vietnamese grave?"; (b) *Hypervigilant-based:* "Because you were Asian, were you ever especially alert or on guard about being treated negatively by other GIs?"; (c) *Stigma-based:* "How often, if ever, did you feel like you 'stood out' in a negative way?"; (d) *Discomfort based:* "Did Asian-bashing remarks made about others ever make you feel uncomfortable or hurt?"

To conduct diagnostic or treatment sessions with AA veteran in which sensitive, potentially traumatic race-related stressors are discussed requires confidence on the part of the veteran *and* the clinician that these issues can be discussed in a safe and supportive milieu. If the clinician and/or veteran feel that confidence is lacking, it is incumbent on *the clinician* to initiate a referral to another provider where such confidence is possible and then, for the clinician to seek training and greater sensitivity to ethnic and race issues.

Diagnosis and Treatment Related to Ethnic Self Worth

Based on clinical experience, we contend that issues of self-esteem and self-worth are particularly central to treatment of AA Vietnam veterans. It is our clinical experience with both AA and other Vietnam veterans that racial denigration of the "enemy" can be injurious to a military soldier's or veteran's sense of worth whether a war is won or lost. For the AA, the psychological injury can be magnified. Racial denigration has been reported to us by Vietnam veterans seeking treatment as having harmful consequences, even to non-AA veterans. To illustrate, if the enemy has been treated with *disrespect* and the war is *won*, it is a hollow victory. If the enemy is treated with *disrespect* and the war is *lost*, the loss cannot be attributed to the formidableness or ability of the opponent (Loo, 1998a). The losing nation cannot explain the loss, and the veterans are an uncomfortable reminder of that loss. Even a "loser" can be perceived as worthy if the "winner" is respected.[1] For the AA Vietnam veteran, the consequences to self-worth are potentially more injurious.

The AA veteran may have been identified with or mistaken for the racially denigrated "enemy" (Asian) while concurrently identifying with those who "lost" the war (American). For the AA veteran, "double jeopardy" can refer not only to race-based negative encounters in the field but also to possible psychological stresses connected to their military service in Vietnam and elsewhere while on active duty.

[1]It is important to note that many Vietnam veterans, both treatment seeking and non-treatment seeking, take great exception to being called "losers" in regard to the Vietnam war. The objective issue in treatment is to address the implications that are present when a veteran is identified by others and/or by himself as a "loser." Such an issue is particularly salient for AA Vietnam veterans because they may have been identified, by others and/or self, with the "loser" or the "enemy."

The clinician would do well to inquire about the veteran's sense of ethnic self-esteem *before* and *after* serving in the Vietnam war. Using two time frames, the clinician could inquire "Prior to your military service, how did you feel about being of Asian ancestry?" After the veteran's response, the clinician can then ask: "And *after your military service,* how did you feel about being of Asian ancestry?" The clinician can inquire about whether the veteran ever had any experiences in which ever wished that he or she were not Asian, and what lasting effects this may have had. Clinically, veterans with racial self-hate due to internalizing anti-Asian attitudes during the war seem to show the greatest difference, in the negative direction, of premilitary to postmilitary attitudes about being Asian.

Exposure to race-related events may be cumulative and repetitive—and not necessarily consisting of a discrete event that readily meets the exposure criteria for a PTSD diagnosis. The clinician is asked to consider the phenomenon of "insidious trauma" (Root, 1993)—the subjective experience of repetitive and cumulative stress that is perpetrated by persons with power toward persons of lessor power—as applicable to an assessment of cumulative race-based trauma.

Insidious trauma in these AAs creates and reinforces assumptions that the world and life are unfair, that White people are malevolent, and that one's life has little worth or meaning. This concept also has been applied to the description of the sequelae of repetitive, cumulative sexual abuse (Herman, 1992, 1993). Assessment for the impact of race-based insidious trauma should include consideration of possible dissociative and/or psychological conflicts regarding ethnic (or self) identity, damaged ethnic (or self) identity, grief or anguish regarding one's ethnicity, difficulties in relationships with persons of either the stigmatized or perpetrator's race, changes in affect related to ethnic identity, or ambivalence resulting from dual identity as an ethnic minority and as an American.

Conclusions

Exposure to race-based stressors that occurred among minority American military personnel during the Vietnam war, and in particular among AA veterans, has received relatively little attention in the literature. We contend that race-related stress as a potential contributor to PTSD needs to be studied. It is our hope that this article will provide a framework in which to consider theoretical, assessment, and treatment implications of exposure to race-related stressors.

Although dehumanization of the "enemy" may serve the purpose of facilitating combat troops to kill other human beings, our clinical observation is that race hate serves little constructive purpose, psychologically or politically. Ultimately, there is a demeaning of all parties involved, as well as the military encounter itself. From a clinical standpoint that interfaces with political dynamics, the bitterness and indeed hatred of many veterans toward Vietnam (and Vietnamese), which we suggest should be at least partly understood in terms of race-related issues as described in this article, sorely complicated the postwar relationship between the United States and Vietnam. In effect, it contributed to a virtual embargo and isolation of an entire country (Vietnam) by the United States. Ironically, from a clinical perspective, such an antagonistic stance toward Vietnam existed for more than a decade during which time (a) Vietnam veterans of all races were denied a potentially very powerful therapeutic component of postwar recovery—access (via media and visits) back to the "site of the original trauma" that has been such an unforgettable and vivid legacy for more than a half-million Vietnam veterans with PTSD (Scurfield, 1989); and (b) continuing race-related denigration of Vietnamese (and by extension, other Asians) was perpetuated, making it difficult for many Vietnam veterans to recover from the war and its race-related stressors.

From a psychological and clinical standpoint, we maintain that exposure to race-related stress did little positive for the self-worth of AAs who fought in Vietnam. Clinicians are urged to carefully explore possible traumatic consequences of race-based experiences during military service on the ethnic identity and self-esteem of AAs (and other veterans). Statements like "There's a weird twist to it if you're Asian," or "It's a mental fight being Asian in that war" (Loo, 1998a) reflect what may be psychological conflict or distress related to a *bifurcation* of the veteran's ethnic identity. As one veteran expressed it:

> One side of me is reaching out with my heart while my hands and arms are stabbing them, abusing them. . . . I was laughing at them, which was a mask for feeling like crying. I had to become a supergook to survive, to prove I was American. I have tremendous guilt for not shedding a tear over them, those who were my brethren. I lost great respect for myself for what I did (Loo, 1998a).

We propose that race-related experiences of AA veterans might also include positive effects of being Asian in that war. Did identification with the Vietnamese, Viet Cong, or North Vietnamese Army (NVA) have any positive effects on AA veterans, such as identification with or admiration of the tough, hardy, persistent, and effective guerrilla tactics of the Viet Cong or the tactical brilliance of the NVA? Did positive experiences with the Vietnamese people have a psychologically buffering effect on negative experiences of war or combat? Did any advantages of being Asian in that war serve a functional purpose for AA veterans? These and other compelling questions are waiting for empirical investigation and should add substantially to our understanding of ethnic and racial considerations regarding mental health and coping.

Also, our clinical exposure to date suggests that there may be a phenomenon that could be called "race-related PTSD." We presume that this model may be a highly controversial but productive topic: *that a psychological disorder associated with race-related, traumatic events could evoke the full inclusionary criteria for a PTSD diagnosis.* Should such a phenomenon exist, we suggest that additional qualifiers need to be considered to the DSM definition of PTSD, such as the stressor criteria, including the underlined portion: ". . . exposure to a traumatic event in which the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others" *where one is targeted because of race or ethnicity.* In addition, we suggest that there be further exploration of the concept and phenomenon of insidious or cumulative trauma exposure, both race-based and otherwise, rather than only considering a discrete event or series of events. Finally, we suggest that for race-related assessments, the person's response to the event include intense fear, helplessness, or horror *or other responses that may reflect aspects of an ethnic minority's more typical response to such stressors, such as detachment, isolation, alienation, avoidance, or somatic reactions.*

Although it is beyond the scope of this article, readers are invited to consider that the concepts described regarding race-related trauma are not restricted to the context of the Vietnam war-zone or even to the context of war. It is our assumption that most of the principles and dynamics that we have identified and discussed have applicability to race-related aspects of a range of traumas. We note that the psychometric scale development in the field of PTSD in large part began with instruments specifically designed to assess exposure to war-zone trauma, such as the "Mississippi Scale for Combat-Related PTSD" (Keane, Caddell, & Taylor, 1988) or the "Civilian Version of the Mississippi PTSD Scale" (Stamm, 1996; Wilson & Keane, 1997). Hopefully, the research currently being conducted to construct a race-related exposure scale for AA Vietnam veterans will contribute to a foundation for further research and development about race-related stressors and PTSD as applicable to a wide number of

ethnic minority groups and to an array of trauma.

Finally, we note that the Hawaii Vietnam Veterans Project (HVVP) should provide useful data on the incidence of PTSD among Japanese American and Native Hawaiian veterans as well as American Indians. However, the HVVP data on ethnically related experiences do not provide a scale on which wide variations and correlations can be assessed, and are limited to only one AA group—Japanese Americans. Furthermore, the HVVP is not an in-depth investigation of race-related stress. Finally, the investigation and understanding of ethnicity requires refinement and elaboration to fully appreciate the rich tapestry that characterizes ethnic, cultural, and racial identity, self-esteem, acculturation, and values—and the interrelationship of such with salient biopsychosocial processes and outcomes.

The field of cultural diversity and mental health encompasses the investigation of ethnicity and trauma. We encourage a full analysis of the compelling and relatively unexplored phenomena that include race-related stressor exposure and outcome. Such bridging of the sociologic and psychologic/psychiatric fields is expected to significantly broaden our understanding of the intimate relationship between race/ethnicity and mental health.

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